

Female Survivors of Military Sexual Assault:

Living with PTSD

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Dedication

I dedicate this paper to all of the military women fighting for our country, especially those who have endured sexual assault and those that are no longer with us. I hope that this paper opens the eyes of all health care providers and help them to better understand the struggles of these female soldiers.

I especially dedicate this paper to my mother, Yvette Colvin, for being the person I look up to and cherish with all my heart. Thank you for sticking by me no matter the circumstances. I would also like to thank my classmates, Phil Johns and Temeki Hill for helping me through the long nights and tears of PA school even though they had to focus on their own projects and daily life.

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Introduction

Military sexual assault against female soldiers is an issue that has become more prevalent in the recent years, specifically since the beginning of the current wars in Iraq and Afghanistan. It may have been an issue in prior years as well, but with the help of many advocates, female voices are now being heard and more women are coming forward, telling their personal stories of sexual assault. In the predominately male populated military, women make up 15% of the approximately 1.4 million active duty soldiers (Infoplease, 2008; Department of Defense, 2007). Of that 15%, 23-30% report being victims of sexual assault, whether it was an inappropriate gesture or physical penetration (Sadler, Booth, Nielson, & Doebbeling, 2000).

With the recent wars in Iraq and Afghanistan, female soldiers have been sent on multiple deployments, where not only are they battling the stresses of combat, but many are confronted with the devastation of becoming victims of sexual harassment. The military, like many other team-oriented professions, is geared toward working together as one. These females enlist in the military, like most individuals, to aid in the protection of their country as well as to better themselves, but are challenged with being sexually harassed by their male officers. Furthermore, many of these female victims are harassed by their superior officers (Campbell & Raja, 2005). These are the very same officers whom they are supposed to rely on for protection should anything go wrong while on duty. If these women cannot trust their commanding officer, who else can they confide in? Moreover, if these women are confident enough to report it, the person that she would be reporting to will most likely be male, which may sway her altogether from reporting the incident. Many of these enlisted women have the fear that should they report their colleague, no one will believe them; they will be further harassed by their attackers; and more disturbing, they fear the possibility of being labeled as not being mentally stable to remain in the

military and thus will be discharged (Valente, 2007). So, not only are they left to deal with the emotional and physical effects of the sexual trauma by themselves, many of them go on to develop other mental health issues, specifically post-traumatic stress disorder (PTSD), gynecological issues, marital issues such as intimate partner violence (IPV), substance abuse, and some resort to suicide. For many of them, these issues are manifested in their home life once they return to society.

The aftermaths of such a violent act has broken up marriages and families, often leading to worse mental and physical health issues for these female soldiers. In the end, many of the women who have decided to do a good deed for their country are now victims of the dreams they set forth to accomplish. Some who decide to seek help may not have as hard a time re-adjusting to their natural environment once they return home. These women may have a primary-care provider, whether it is at a Veteran Affairs (VA) medical center or their own private hospital who know what signs to look for and have the resources to deal with sexually assaulted female soldiers. But there are some women who do not have that luxury or may be too scared to get treatment because of the stigma that comes with it. For the sake of those women who do not have the proper resources or are too scared, all primary care providers, especially physician assistants (PAs), need to be adequately prepared to provide the proper assessment, treatment and/or referrals if necessary, because the primary care provider will likely be the first to have contact with these victimized female soldiers.

This literature review will focus on female soldiers returning from the wars in Iraq and Afghanistan, commencing September 11, 2001, to present. The targeted populations will include female veterans who have been diagnosed with PTSD as a result of sexual assault during military combat. Supporting information addressing the history of female soldiers as well as the rates of

sexual assault and PTSD will be cited from prior wars, mainly Vietnam and the Gulf war, to provide the significance of the issue. The current diagnostic tools for assessing PTSD and sexual assault will be reviewed for their current efficacy. Many of these women may not have received or sought treatment, which may lead to the development of other physical and mental health issues resulting from untreated sexual assault and PTSD. The issues these women face are many and will not all be addressed, but those that will be include suicide, substance abuse, gynecological issues, and marital/family life issues (intimate partner violence and homicide). The articles to be reviewed will include peer-reviewed articles, research articles, government websites, newspaper articles, and databases such as MEDLINE and PubMed, and will be searched within the dates of 1990 to present. Articles comparing the current war on Iraq and Afghanistan to prior wars, mainly Vietnam and the Gulf War, will be taken from over the years 1965 to 1991.

Sequelae and Quality of Life Issues Associated with Sexual Assault

Sexual assault is an issue that has not only been undermined in the civilian population, but in the military as well, which has been a major setback in reporting the incidents. As mentioned earlier, many of these females fear that no one will believe them, or worse, they will be blamed for their becoming the victim (Campbell & Raja, 2005). Because of these barriers, many women do not report sexual assault, but will present to their primary care provider complaining of other mental and/or physical symptoms such as bodily pain, gastrointestinal disturbances, depression, and an overall decreased quality of life (Dobie et al., 2004; Sadler et al. 2000). Moreover, depending on the severity of the sexual assault; single, multiple or gang rape, many women may present with a more chronic form of mental or physical illness. In a study conducted on the health consequences of gang and multiple rapes during military service, Sadler, Doebbeling and Booth (2005) found that those who were gang raped or raped multiple times had the poorest health status compared to those that experienced no rape or a single rape during military service. These women were also more likely to utilize more inpatient and outpatient medical services for their illnesses.

These findings from the Sadler et al. (2005) study support the fact that military women who are sexually assaulted are utilizing the primary-care offices for treatment; no matter what their chief complaint is when they present. There are multiple symptoms and pathologies which may be directly or indirectly related to sexual assault, PTSD being of particular importance, and others including, but not limited to, gynecological issues, substance abuse, intimate partner violence (IPV), and suicide which will all be discussed in this paper. Because of the complex course that sexual assault can have on these women, all primary-care providers need to be aware of the possibility of sexual assault when confronted by female civilians as well as military

veterans presenting with multiple mental and/or physical complaints. However she may present to her primary care provider, if the question of sexual assault is not addressed during her visit, she will likely not volunteer the information and will now be left to continue a long road of emotional, physical and mental problems on her own, which may lead to even more chronic courses of her illness/es or it may encourage her to self recover on her own. Whichever path she follows, it is the responsibility of her health care provider to seek information and ask her the necessary questions to provide her the best quality of care.

Gynecological Issues

Gynecological issues have been found to persist in women who have been sexually assaulted, whether it occurred in the military or as a civilian. Campbell et al. (2006) found that women who had been sexually assaulted reported having increased occurrences of pelvic pain, vaginal bleeding/discharge, and painful intercourse. Repetitive bouts of vaginitis, yeast infections and urinary incontinence are also among the symptoms that correlate with sexual assault (Frayne et al., 1999). The likelihood of developing a sexually transmitted disease (STD) is an issue that should be worried about as well. The most commonly reported STD findings in sexually assaulted females are *Chlamydia trachomatis*, *Trichomonas vaginalis*, and *Neisseria gonorrhoeae* (Lacey, 1990), which have the potential to cause serious gynecological issues if not properly treated. As these findings may seem trivial to some individuals, these women have to deal with issues that could have been avoided if the sexual assault did not occur. Moreover, infertility and miscarriage are also prominent problems some of them have to endure as a result of their sexual assault. Frayne et al. found that of the 23% (n = 805) of a national sample (n = 3543) of female VA outpatients who reported being sexually assaulted in the military, 21%

reported having problems getting pregnant. Furthermore, 46% (n = 805) reported having ever lost a pregnancy. As all of these findings may or may not be a direct result of their sexual assault, women who have been sexually assaulted, specifically in the military, have been found to report symptoms as such in higher numbers than those who were not sexually assaulted (Sadler et al., 2000).

Substance Abuse

As substance use and/or abuse is a public health concern that is prevalent in the United States in general, individuals that have been confronted with trauma, specifically sexual assault, are more at risk for the development of a co-morbid substance abuse disorder. Females in a military environment, which in itself can be traumatic, are at high risk for sexual assault, thus placing them in a situation where substance use may initially be a coping mechanism for sexual assault, but for some it eventually becomes an addiction. As many would suspect, any traumatic event can be very devastating, but in the case of a female who has been sexually assaulted while on active duty, the traumatizing effect may be more drastic; as she may also be experiencing the general traumatic stress one develops when involved in military combat. Although she may have the combat related traumatic stress, many studies have found that the stress related to sexual assault is more traumatic overall (Davis & Wood, 1999; Gil-Rivas, Fiorentine, & Anglin, 1996). Furthermore, sexual assault brings with it a stigma that many females do not want to bare should they report the incident, which initiates even further stress and a multitude of coping mechanisms if proper treatment is not sought. Because many women choose to deal with the results of sexual assault internally, mental and emotional issues prevail, which have been found to increase the likelihood that they will self-medicate on substances such as alcohol, marijuana, cocaine/crack

and opiates (Davis & Wood; Walker et al., 1995) to suppress the feelings. Walker et al. found that 12 percent (N=1,698) of a national sample (N=13,735) of female veterans were discharged with a diagnosis of at least one substance use disorder; some (71 percent) having a diagnosis of alcohol dependence, drug dependence, or both. This particular study was not conducted to determine how many of these females were sexually assaulted prior to abusing substances, but it does bring to the forefront the high prevalence of substance abuse amongst female veterans. Unlike Walker et al., Gil Rivas et al. found that 61% of their outpatient substance abuse sample reported a history of sexual trauma. Moreover, Paone et al. (1992) found that 51% of their female subjects who reportedly abused substances also reported being victims of at least one forced sexual encounter. Although these findings were found in civilian females, those in the military are at higher risk for sexual harassment, being in a male dominated environment; thus making it more likely that studies may find more substance abuse in female veterans that were sexually assaulted. McFarlane et al. (2005) found that women who reported sexual assault were 3.5 times more likely to report beginning or increasing substance use compared to women who suffered a single incidence of sexual assault. Davis and Wood indicated that 88.9% of their female veteran subjects who reported substance abuse also reported sexual abuse. Because this study is limited by the small amount of subjects (N=28), the results cannot be generalized to all female veterans presenting with substance abuse and/or sexual harassment, but it does make one question the high occurrence of sexual assault and substance abuse in these females. If 26 out of the 28 reported sexual and substance abuse, one could just imagine that this number would likely increase should the number of subjects increased. This study may also be justified by the fact that many of the female veterans that report military sexual assault were also assaulted in their civilian life as well; some pre-military, post-military, or both. Suris, Lind, Kashner, and Borman

(2007) found that of their 270 female veteran participants, 33% reported military sexual assault, 38.9% reported civilian sexual assault, and 27% reported childhood sexual assault. Furthermore, 14% of those who reported military sexual assault also screened positive for current alcohol abuse symptoms. Although a lot of the current research is conducted on civilian females, one must remember that the military does not take away a soldier's gender; they are still male or female and the same illnesses and conditions face them as well if not more often. As these studies are only a glimpse at what some of these female veterans deal with as a result of military sexual assault, healthcare providers need to be aware of the multiple illnesses these females deal with other than just the sexual assault because as shown here many of them have co-morbid substance abuse disorders.

Intimate Partner Violence

In addition to the direct physical effects of sexual assault, some of these females also become victims and/or perpetrators of intimate partner violence (IPV) once they return home. The US Department of Justice defines IPV as violent crimes including lethal (homicide) and non-lethal (rape, sexual assault, aggravated/simple assault, robbery) offenses committed by a current or former spouse, boyfriend or girlfriend (Rennison & Welchans, 2000). IPV is an issue that has unfortunately been seen too often in the military community. In a 1991 survey, Hamlin et al found that spouse abuse ranked the third most frequent problem in the military behind alcohol abuse and child abuse. Forgey and Badger (2006) found that although married military women are equally likely as their male civilian spouse to inflict minor violence on their spouse, they were 3 times more likely than their male civilian spouses to be victims of unilateral severe violence. While IPV is an issue that can manifest in any type of relationship; married,

divorced/separated, widowed, or single, it has been found that many of the women inflicted with physical and/or sexual violence were either separated/divorced (Campbell et al., 2003; Sadler et al., 2000). Furthermore, multiple studies have found that many women enlist in the military as a safe haven to escape an abusive relationship, but are faced with the very thing they were trying to avoid, which for some, further damages their psyche and sets them up for the development of other mental and physical health issues. As these statistics shed light on the prevalence of IPV in the lives of military women, they also provide a picture into the lives of some females who have been assaulted prior to enlistment, while on active duty, and moreover, have to come home to a violent relationship which may involve further sexual and/or physical assault.

Suicide/Femicide

While many people may view suicide as taboo, it is a very real incidence that inflicts many families more often than one would expect, in the civilian sector as well as in the military. In a recent study (1990-2000) comparing suicide rates in the military to suicide rates of civilians, Eaton, Messer, Wilson, and Hoge (2006) found that the overall conservative (confirmed suicides) civilian population suicide rate in 2000 was 12.31/100,000/year and the military rate was lower at 8.31/100,000/year. Also, the researchers concluded that the range for suicide rates (6.5-9.1/100,000/yr) between the branches were pretty similar. While these numbers show a lower rate of military suicide compared to civilian, the Army recently released suicide data concerning soldiers in Iraq and Afghanistan which revealed that the rate has increased.

The Army's suicide rate for soldier's in Iraq and Afghanistan, not including other military branches, for 2006 alone was 17.3/100,000 soldiers, compared to the US population suicide rates of 19/100,000 people (Wood, 2007). Also, the 2003-2006 average Army suicide

rate of 16.1/100,000/year versus 11.6/100,000/year prior to 2003 (Wood; Harben, 2006) indicates that suicide has become a way of coping for some of the soldiers. These numbers are limited for the purposes of this review because they do not reveal gender differences or the reason for committing suicide, but they do reveal the presence of mental health issues these soldiers are dealing with, which they cannot control; unfortunately leading to their death. In the suicide rates presented above, it was stated that the deaths were attributed to poor interpersonal relationships, financial, occupational, and legal issues. Furthermore, unless the person left a note behind or some type of evidence stating why they chose to take their own life, it is hard to determine the factors surrounding the death. This lack of evidence can cause one to assume that these numbers are likely higher than what is reported. These numbers are not exponentially significant, as suicide is not reportedly occurring at high rates, but as many would agree, one death by suicide is too many, especially when it could have been prevented.

While the military is a predominately male organization, many of the presented suicide rates are representative of male soldiers who are currently on active duty in Iraq and Afghanistan, which does not take into account the male or female soldiers that committed suicide because of military related health issues once they returned to their civilian life. While there have not been many studies conducted on female veterans who have attempted or completed suicide because of military sexual assault, research on civilian females having single or multiple sexual assault encounters have shown a significant association with attempted suicide. Many of these female veterans are dealing with the health issues once they return to the civilian sector; this warrants the need for further research on military sexually assaulted female veterans who have attempted or completed suicide upon returning to civilian life.

McFarlane et al. (2005) found that women reporting sexual assault were 5.3 times more likely to report threatening or attempting suicide compared to those not sexually assaulted. In addition, 76 percent reported that the perpetrator threatened to kill them, which was one of the fifteen femicide risk factors that all those who had been sexually assaulted were found to report at significantly higher rates than those reporting physical assault only. Although this study was conducted on civilian intimate partners, as mentioned earlier, the military has its share of intimate partner violence amongst its soldiers. Davidson, Hughes, George, and Blazer (1996) concluded that women who had been sexually assaulted reported significantly higher (14.9% vs 1.4%) rates of suicide attempts compared to those who had not been raped. Furthermore, this same study revealed that women who reported rape encounters prior to the age of 16 were 3 to 4 times more likely to attempt suicide than those raped at or greater than 16 years of age. While childhood sexual assault exceeds the scope of this paper, studies have found that some military females were sexually assaulted as children (Sadler, Booth, Nielson, & Doebbeling, 2000; Suris et al., 2004), which for some may add on to the current trauma they may face should they be one of the 23% of female veterans sexually assaulted in the military. One can imagine the betrayal and disgust these women may feel, especially if she had not personally dealt with the emotional and physical symptoms they have endured from the childhood sexual assault, which may have included suicidal ideation or attempts. If these women have to suffer the same victimization as an adult, their suicidal behavior may not be just an ideation or attempt anymore, but may now become a completed suicide.

On the flip side of the coin, femicide has become a huge issue in the US with IPV as the major culprit. According to the US Department of Justice (2000), females are 5 to 8 times more likely than males to be victimized by an intimate partner and women are more likely to be killed

by an intimate partner than males (Garcia, Soria, & Hurwitz, 2007). Sharps et al. (2001) found that 81% of their femicide sample were physically abused by their perpetrator the year prior to the femicide, 23% were beaten while pregnant, and 72% reported victimization of harassment and stalking. As these numbers are a reflection of the US in general, the military also has its issues with marital discord. According to the National Coalition Against Domestic Violence (NCADV, 2001), domestic violence homicides in the military included 54, 131, and 32 since 1995 for the Navy or Marine Corps, Army, and Air force, respectively. It was also found that the rates of moderate and severe spousal abuse had increased from 23 percent to 36 percent and 2 percent to 7 percent respectively, with mild spousal abuse decreasing from 72 percent to 57 percent between the years 1997 and 2001 (NCADV). Moreover, over the course of six weeks in June and July of 2002 there were five domestic homicides at Fort Bragg army base involving the death of 4 women and 1 male with 3 perpetrators recently returning from Afghanistan (Family Violence Prevention Fund, 2002).

A number of military deaths involving female soldiers have come up in news media, many of which are attributed to suicide but are being further investigated as possible homicides. For example, “8 women soldiers from Fort Hood, Texas (six from the Fourth Infantry Division and two from the 1st Armored Cavalry Division) have died of “non-combat related injuries” on the same base, Camp Taji, and three were raped before their deaths. Two were raped immediately before their deaths and another raped prior to arriving in Iraq. Two military women have died of suspicious “non-combat related injuries” on Balad base, and one was raped before she died. Four deaths have been classified as suicides.”(Wright, 2008). While IPV has been an on-going issue for the military for many years, they have developed programs to aid families

suffering from domestic violence, but evidently more needs to be done to aid these soldiers because homicide is becoming more prevalent.

Post Traumatic Stress Disorder (PTSD)

PTSD is on the up-rise in female veterans, not only due to their physical participation in combat, but also because of the increasing occurrence of sexual assault, lengthy and frequent deployments to combat, and many other factors involving military life. According to the DSM IV-TR (American Psychiatric Association, 2000), PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor. Traumatic stressors include, but are not limited to, military combat, violent personal assault such as sexual assault, physical attack, robbery, mugging, kidnapping and torture. The symptoms that manifest are re-experiencing the event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal, which have to be present for more than one month. The average single deployment length for Iraq or Afghanistan ranges from 4 to 15 months depending on the branch of service. The Army recently issued a 15-month standard deployment length, which is the branch of service in which women are more likely to serve (Campbell, Lichty, Sturza, & Raja, 2006). If sexually assaulted within that first month these women have to wait it out for 14 more months dealing with the aftermath and fear of having been victimized; each having ample time to develop PTSD.

Furthermore, these women are also dealing with the stresses of military combat in general, which has been proven to cause PTSD in itself. According to a recent study by Hoge et al. (2004), conducted on soldiers returning from Iraq and Afghanistan, as many as 17 percent of soldiers may be at risk for mental disorders including PTSD. PTSD among the general

population is 3 to 4%, which is similar to the rate of 5% amongst soldiers prior to deployment (Hoge et al.), which further shows that military combat in general is a major stressor among soldiers. Unlike prior wars, women are now participating in nearer proximity to ground combat, which has put them closer to the face of danger. They are also faced with the deaths of their fellow soldiers, bombs blowing up around them, and many other combat related stressors. As PTSD is an individualized mental health issue, military combat has been associated with a higher incidence compared to civilian individuals with PTSD. Juxtaposed to military sexual harassment, studies have shown that women who have not been sexually assaulted in the military have a lower incidence of PTSD (Yaeger, Himmelfarb, Cammack, & Mintz, 2006). While PTSD can be an accepted reaction to military combat in general, when being sexually harassed during military combat, the occurrence is much more prevalent.

Correlation with PTSD

As one may assume, each of the previously discussed issues in this paper, can bring with it a great deal of distress. When a female is sexually assaulted, whether in the military or as a civilian, she may suffer from one or more of the above issues. As mentioned above, sexual assault has been found to have the highest correlation with the development of PTSD; especially when assaulted while on active duty because of the environment, stigma, and the inability to leave the situation. When proper treatment is not sought for sexual assault, PTSD can become a hard disorder to deal with because the re-experiencing, avoidance, and hyper-arousal symptoms associated with the assault can become unbearable. Although the gynecological symptoms are more related to the actual assault, untreated PTSD can exacerbate those symptoms and cause more problems. Intimate partner violence has been found to be a risk factor for PTSD; with a higher prevalence in battered women than in non-battered women (Campbell, 2002). PTSD may become even more unbearable in this cohort because they have to see their perpetrator everyday and continue to endure the abuse, which is why many women find alternative coping methods, such as drugs and alcohol to escape the reality of intimate partner violence (Campbell). Women who did not endure their sexual assault by an intimate partner are also found to abuse alcohol and drugs to cope with the symptoms of PTSD (Campbell; Gil-Rivas, Fiorentine, & Anglin, 1996).

As there are multiple methods to cope with sexual assault and the PTSD symptoms that develop, unfortunately suicide is a method that some women may choose because they can no longer deal with the agonizing symptoms. Tarrier and Gregg (2004) concluded that suicide risk is increased in those suffering from chronic PTSD. While military veterans are generally at high risk for PTSD, those who are sexually assaulted are at higher risk for PTSD and attempted

suicide (Tarrier & Gregg). While some women resort to suicide, others have their fate chosen for them in which their perpetrator takes their life, specifically among those in intimate relationships. Homicide among women is a public health issue that has received a lot of attention in the US, which has lead to increased efforts to aid in decreasing the incidence. According to the US Department of Justice (2002), "Intimate murders accounted for 30% of all female murders (Garcia, Soria, & Hurwitz, 2007). While each of these issues brings with it its own symptoms, PTSD has been found to be a huge factor because of its relation with sexual assault, which is why women presenting to primary care offices need to be properly assessed for sexual assault.

Primary Care Utilization of Female Veterans

Sexual assault is a traumatic event that brings with it a number of long-term consequences; PTSD being most prominent. While sexual assault has been linked with increased health-care utilization in general, those with co-morbid PTSD have been found to use health-care services in more abundance (Dobie et al., 2006; Sadler, Booth, & Doebbling, 2005). Although there are studies suggesting that women are utilizing more VA health care services, only a few have focused specifically on primary care, which is where the majority of individuals are initially screened. Most studies are conducted to determine the sequelae and quality of life issues associated with sexual assault, mainly PTSD. Because the majority of studies on female veterans are conducted on those utilizing VA services, one would ascertain that these women are using health care services being offered at the VA, whether it is for general medical exams, routine gynecology visits or specialty services.

Suris et al. (2004) found that 54% of a sample of 230 female veterans that had been sexually assaulted had an average health care cost of approximately \$14,781, which was found to be higher than their comparison group of female veterans with no sexual assault history whose average costs were \$10,061. Dobie et al. (2006) found that women who tested positive for PTSD were more likely to be hospitalized for medical or surgical conditions and they utilized more outpatient services such as the emergency department, primary care, subspecialty care, ancillary services, and diagnostic testing. In addition, the availability of women's health clinics has allowed for more comprehensive and improved quality of care for those seeking care through VA services (Washington et al., 2003; Washington, Yano, Simon & Sun, 2006), but the problem arises when these women come in seeking care for the sequelae they have developed from their sexual assault and their undiagnosed PTSD. While the VA offers clinics for women's health,

some women also utilize facilities outside the VA, which further justifies the need for all providers to be able to address these women's issues.

Primary care providers are usually the initial facilitator in assessing health conditions for most patients in the VA and in the private sector. Being that the primary care provider is the initial contact; one would assume that their screening would detect certain physical and/or mental health illnesses their patients present with in the clinic. Contrary to the assumption, studies have shown that primary care providers, specifically in office settings, fail to diagnose and treat 50% to 75% of patients suffering from common mental disorders (Borus et al., 1988; Kessler et al., 1985; Ormel et al., 1991; Rydon et al., 1992; Spitzer et al., 1994). Yano et al. (2003) found that 56% of the female veterans receiving care at the VA obtain most of their care in general primary care, where they can then be referred to the specialist of choice should the need arise.

Women's health care services vary depending on the availability of women's health clinics, and the amount of services provided by the general primary care clinic at VA facilities. As demonstrated (figure 1), 26% of VAs have both women's health providers in primary care and separate women's health clinics, 21% rely only on women's health through primary care, and 28% rely solely on women's health clinics, and 24% have neither arrangement (Yano et al., 2003). Furthermore, Yano et al. also found that more women's health care services were provided through a referral to a specialty women's health clinic compared to those services provided by the primary care clinic or a designated women's health primary care provider (table 1). This suggests that the primary care provider is the first assessor for most female veterans.

Second to the primary care provider, obstetrician-gynecologists are an important aspect in the care of sexually assaulted females. According to the American Medical Association (1992),

29% of all ambulatory visits for women aged 15-44 years of age are to the obstetrician-gynecologists (Sadler et al., 2000). Furthermore, Scholle, Chang, Harman, & McNeil (2003), found that obstetrician-gynecologists identify themselves as primary care providers for 20% of their patients. This suggests that gynecologists need to properly assess for sexual victimization and the signs and symptoms of its sequelae because some women presenting to their gynecologist do not seek care from their designated primary care provider.

Efficacy of PTSD and Sexual Assault Assessment/Diagnostic Tools in Primary Care

PTSD Checklist

Primary care providers, especially PAs, are unique to the medical profession in that they encounter a plethora of illnesses and diagnoses from minor physical or mental complaints to major life altering illnesses, which may exceed their scope of care. Nevertheless, each complaint should be taken seriously and the proper assessment of the complaint should be conducted, which is where tools such as the PTSD checklist and sexual assault assessments become useful. Because PTSD occurs more often than not in military veterans, the primary care provider should have access to the assessment tools needed to diagnose and treat PTSD. Furthermore, the diagnoses of PTSD may shed light on other medical problems such as sexual assault, substance abuse, IPV, and suicidal ideation, which may decrease the amount of money and time being used on healthcare services by those not being treated for their PTSD.

There are multiple assessment tools for screening patients who have suffered a traumatic event, but the tool most often used in primary care settings is the PTSD checklist (Weathers, Litz, Huska, & Keane, 1994) including a civilian (figure 2) and military version (figure 3). Nonetheless they both include a checklist of 17 self report questions administered by the primary care provider, which can be completed in less than ten minutes, to determine the prevalence of PTSD symptoms that meet criteria under its 3 diagnostic clusters; re-experiencing, avoidance/numbing, and hyper-arousal, one may be experiencing in relation to a traumatic event. The patient rates how much each symptom has bothered them in the past month using a 5-point scale (1=not at all to 5=extremely).

Studies have found that the PTSD Checklist-civilian version has good reliability when screening for PTSD in primary care clinics (Dobie et al., 2002; Lang, Laffaye, Satz, Dresselhaus,

& Stein, 2003; Grugbaugh, Elhai, Cusack, Wells, & Frueh, 2007), but the issue that arises in primary care clinics is time constraints, which can decrease the likelihood that the proper screening will take place. In an effort to mitigate screening time, Lang and Stein (2005) found that their abbreviated 2 item and 6 item PTSD checklists may be useful diagnostic tools to screen for PTSD. These abbreviated checklists were found to have similar sensitivities, .96 and .92 respectively, as the original 17 item checklist, .96, see fig 2. The specificity was found to be better in the 6-item checklist (.72) in comparison to the 2-item (.58) and 17-item (.59) checklists, suggesting that it may cut-back on screening time and properly screen for potential PTSD patients.

Another issue that arises when screening for PTSD is the total score cut-off one would use to determine which individuals meet diagnostic screening criteria. The developers of the checklist used a cut-off of 50, which was conducted on male Vietnam veterans, a subset of individuals that have a high risk of developing PTSD. Multiple studies have been conducted to find an optimal cut-off, which fell in the range of 30-50 depending on the subjects being tested (Lang & Stein, 2005; Grugbaugh et al., 2007, Lang et al., 2003; Dobie et al., 2002), suggesting that one must choose the optimal cut-off based on the clinical setting, and the patient population.

Sexual Assault Assessment

While sexual assault assessments can vary from provider to provider, each should include a sexual assault history, proper examination for forensic evidence, a psychological screening, such as the PTSD checklist, and most important, empathy for the victim. The provider must be empathetic about the situation in order to make the victim feel comfortable and safe. While some providers are adequate at providing proper assessment, others have made the victim feel as if she

were being re-victimized. Campbell & Raja (2005) found that military women who sought treatment at military medical facilities were made to feel as if they were to blame for their assault and made them more reluctant to seek further help. While most of these reported issues were emotional, those who sought treatment at civilian facilities reported more behavioral issues on behalf of the health care provider, such as rushing the exam, not being attentive to their emotional state, and not explaining the sequelae associated with sexual assault. While this study has its limitations, it sheds light on the need for proper training of health care providers on sexual assault assessments, in military and civilian medical facilities so that one has a comfortable experience and not feel as if she were being blamed for her assault.

As mentioned previously, women who have been sexually assaulted have a high probability that PTSD will develop, especially in female veterans. While sexual assault assessment tools may elicit specific and valuable information about the perpetrator, most women do not immediately seek help for their assault, which decreases the likelihood that specific evidence will be found. Research indicates that 98% of civilian sexual assault victims make outpatient visits within the first year after their victimization (Koss, Koss, & Woodruff, 1991). Furthermore, women on active duty may be less apt to seek help because of the stigma that surrounds reporting the incident and their inability to immediately leave the situation. With that in mind, many women reporting to their primary care provider may already have symptoms suggestive of PTSD, which is why the PTSD checklist is an excellent tool to elicit certain information from sexual assault victims that chose not to seek immediate help following their assault. While both tools can elicit pertinent information, sexual assault is a very sensitive issue that most women will not voluntarily speak about in a primary care setting unless the information is specifically elicited by her provider (Liese, Larson, Johnson, & Hourigan, 1989).

For that reason alone, it is absolutely necessary that a sexual assault history be elicited for all military personnel, especially females returning from the combat theatre, whether they present with a complaint of sexual harassment or not.

Prevention and Awareness of Military Sexual Assault

With the increase in reports of sexual assault in military females, the Department of Defense (DoD) (2004) has submitted a memorandum (figure 5) requiring the Secretary of Defense to re-evaluate its current strategies in caring for victims of sexual assault. Since this memorandum, the military has established services allowing for increased anonymity, prevention programs, and awareness throughout each of the service branches. In recent years, sexual assault assessment programs, such as Sexual Assault Nurse Examiners (SANE), rape crisis centers, and specifically for the military setting, the Sexual Assault Prevention and Response Office (SAPRO), have become very useful in the management of females that endured sexual assault. They have a better understanding of the types of questions to ask victims, the delicacy of the situation, and the psychological issues that may develop. In an attempt to centralize a specific site for sexual assault victims, the DoD Task Force created SAPRO, which consists of a Sexual Assault Response Coordinator (SARC) and a Victim Advocate (VA), so that women have someone to report to should they be sexually assaulted while on duty or in training, other than to a commanding officer. Upon receipt of sexual assault, the SARC organizes the proper care for the victim and assigns them a VA to aid them in obtaining necessary services such as proper examinations, crisis intervention, referrals, and ongoing non-clinical support for the life of the case (Sexual Assault Prevention and Response Office, 2005).

While the victims care is of primary importance, training all military personnel, including commanding officers, in sexual assault management is conducted by SAPRO as well. SAPRO also collects data concerning sexual assault from each branch of service, creating an ongoing report of sexual assault victims, perpetrators, the investigation, and the final outcome. While there still may be many incidences that go unreported, sexual assault awareness has become an

ongoing process for the DoD. In its efforts to improve the prevention, awareness and support of sexual assault in military settings, the DoD has made strides, which may be the reason that more women are coming forth and reporting their incidence of sexual assault, but evidently more needs to be done being that the numbers for sexual assault is on the rise.

Conclusion

The purpose of this literature review is to inform its readers of the deleterious effects sexual assault can have on female soldiers, specifically those serving in Iraq and Afghanistan. Unlike prior wars, the current wars have a greater number of females, much longer deployment lengths, number of deployments, and more intense job duties. Sexual assault in itself can take a toll on the mental, physical, and emotional aspects of her life, and to add the military component on top of what is already a stressful situation makes things even more magnified, especially when the person who committed the assault is the one she was suppose to confide in.

As demonstrated, these women are suffering tremendously and the need for proper recognition and treatment is something that PAs can accomplish to aid them in adjusting to civilian society. These women have taken the chance with their lives to protect our freedom and country and had to endure things that we may never understand as civilians. Although we were not there as PAs to prevent the sexual assault from occurring, the least we can do is help them get through the after effects and get their lives back together. It is certain that some of them may not want to share this information and they may be afraid because of the possible stigma that comes with it, but that is where we as PAs need to break down these barriers and allow them to feel comfortable talking about their assault.

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Table 1.

Practice Arrangements for Women's Health in VA Facilities

Table 1. Practice arrangements for women's health in VA facilities*

Women's health care services	How health care services are typically provided				
	Provided by PCC	Provided by designated WH PCC	Referred to a specialty women's health clinic	Other arrangement	Not provided at this site
Pregnancy testing [†]	34%	15%	41%	4%	0%
Contraceptive counseling and management [§]	8%	17%	68%	3%	0%
Cervical cancer screening (e.g., Papanicolaou smears) [§]	6%	19%	66%	5%	0%
Clinical breast examination [‡]	10%	18%	62%	6%	0%
Vaginitis evaluation and treatment [§]	8%	19%	65%	4%	0%
STD screening, diagnosis, and treatment [§]	10%	19%	60%	7%	1%
Menopausal counseling and hormone replacement therapy [§]	10%	15%	65%	6%	0%
Osteoporosis management [§]	29%	15%	44%	7%	0%
Sexual trauma screening [‡]	17%	13%	47%	18%	1%

*Among $n = 136$ VA geographically distinct facilities serving 400 or more women veterans (82% response rate).

[†]Missing data for 7 (5.2%) of respondents; [‡]for 6 (4.4%) of respondents; [§]for 5 (3.6%) of respondents.

PCC = primary care clinic; STD = sexually transmitted diseases.

Note. From “The Organization and Delivery of Women's Health Care in Department of Veterans Affairs Medical Center,” by E. M. Yano, D. L. Washington, C. Goldzweig, C. Caffrey, & C. Turner, 2003, *Women's Health Issues*, 13(2), 55-61. Copyright 2003 by Elsevier. Reprinted with permission.

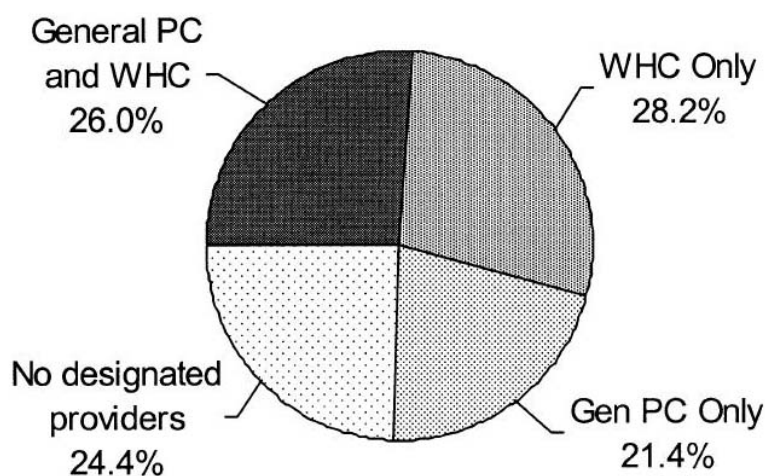


Figure 3. Adoption of different women's health practice models in VA medical centers (among 131 VA medical centers, excluding 5 respondents for whom data were partially missing).

Figure 1. Adoption of different women's health practice models in VA medical centers (among 131 VA medical centers, excluding 5 respondents for whom data were partially missing)

From "The Organization and Delivery of Women's Health Care in Department of Veterans Affairs Medical Center," by E. M. Yano, D. L. Washington, C. Goldzweig, C. Caffrey, & C. Turner, 2003, *Women's Health Issues*, 13(2), 55-61. Copyright 2003 by Elsevier. Reprinted with permission.

Name _____

INSTRUCTIONS TO PATIENT: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, put an X in the box to indicate how much you have been bothered by that problem in the past month.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing <i>memories, thoughts</i> , or <i>images</i> of a stressful experience?	1	2	3	4	5
2.	Repeated, disturbing <i>dreams</i> of a stressful experience?	1	2	3	4	5
3.	Suddenly <i>acting</i> or <i>feeling</i> as if a stressful experience <i>were happening again</i> (as if you were reliving it)?	1	2	3	4	5
4.	Feeling <i>very upset</i> when <i>something reminded you</i> of a stressful experience?	1	2	3	4	5
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, sweating) when <i>something reminded you</i> of a stressful experience?	1	2	3	4	5
6.	Avoiding <i>thinking about</i> or <i>talking about</i> a stressful experience or avoiding <i>having feelings</i> related to it?	1	2	3	4	5
7.	Avoiding <i>activities</i> or <i>situations</i> because <i>they reminded you</i> of a stressful experience?	1	2	3	4	5
8.	Trouble <i>remembering important parts</i> of a stressful experience?	1	2	3	4	5
9.	Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling distant or cut off from other people?	1	2	3	4	5
11.	Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your future will somehow be cut short?	1	2	3	4	5

13.	Trouble falling or staying asleep?	1	2	3	4	5
14.	Feeling irritable or having angry outbursts?	1	2	3	4	5
15.	Having difficulty concentrating?	1	2	3	4	5
16.	Being "super-alert" or watchful or on guard?	1	2	3	4	5
17.	Feeling jumpy or easily startled?	1	2	3	4	5

PCL-C for DSM-IV (11/1/94) END OF TEST

Figure 2. PTSD Checklist, Civilian Version

From “*The PTSD Checklist – Civilian Version (PCL-C)*” by F. Weathers, B. Litz, J. Huska, & T. Keane, 1994, National Center for PTSD- Behavioral Science Division. Retrieved from <http://www.pdhealth.mil/guidelines/appendix3.asp>. In

Name _____

INSTRUCTIONS TO PATIENT: Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully, put an X in the box to indicate how much you have been bothered by that problem in the past month.

		Not at all	A little bit	Moder- ately	Quite a bit	Extre- mely
1.	Repeated, disturbing <i>memories, thoughts</i> , or <i>images</i> of a stressful military experience?	1	2	3	4	5
2.	Repeated, disturbing <i>dreams</i> of a stressful military experience?	1	2	3	4	5
3.	Suddenly <i>acting</i> or <i>feeling</i> as if a stressful military experience <i>were happening again</i> (as if you were reliving it)?	1	2	3	4	5
4.	Feeling <i>very upset</i> when <i>something reminded you</i> of a stressful military experience?	1	2	3	4	5
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, sweating) when <i>something reminded you</i> of a stressful military experience?	1	2	3	4	5
6.	Avoiding <i>thinking about</i> or <i>talking about</i> a stressful military experience or avoiding <i>having feelings</i> related to it?	1	2	3	4	5
7.	Avoiding <i>activities</i> or <i>situations</i> because <i>they reminded you</i> of a stressful military experience?	1	2	3	4	5
8.	Trouble <i>remembering important parts</i> of a stressful military experience?	1	2	3	4	5
9.	<i>Loss of interest</i> in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling <i>distant</i> or <i>cut off</i> from other people?	1	2	3	4	5
11.	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your <i>future</i> will somehow be	1	2	3	4	5

	<i>cut short?</i>					
13.	Trouble <i>falling</i> or <i>staying asleep</i> ?	1	2	3	4	5
14.	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?	1	2	3	4	5
15.	Having <i>difficulty concentrating</i> ?	1	2	3	4	5
16.	Being " <i>super-alert</i> " or watchful or on guard?	1	2	3	4	5
17.	Feeling <i>jumpy</i> or easily startled?	1	2	3	4	5

PCL-M for DSM-IV (11/1/94) END OF TEST

Figure 3. PTSD Checklist, Military Version

From “*The PTSD Checklist – Military Version (PCL-M)*” by F. Weathers, B. Litz, J. Huska, & T. Keane, 1994, National Center for PTSD- Behavioral Science Division. Retrieved from <http://www.pdhealth.mil/guidelines/appendix4.asp>. In the public domain.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing memories, thoughts, or images of a stressful experience?	1	2	3	4	5
2. Feeling <i>very upset</i> when <i>something reminded you</i> of a stressful experience?	1	2	3	4	5
3. Avoiding <i>activities</i> or <i>situations</i> because <i>they reminded you</i> of a stressful experience?	1	2	3	4	5
4. Feeling distant or cut off from other people?	1	2	3	4	5
5. Feeling irritable or having angry outbursts?	1	2	3	4	5
6. Having difficulty concentrating?	1	2	3	4	5

Figure 4. Abbreviated PCL-C. The 6-item version consists of items 1, 4, 7, 10, 14 and 15 from the original 17 item PCL-C. An individual is considered to have screened positive if the sum of these items is 14 or greater. The 2-item version consists of items 1 and 4 from the original PCL-C. An individual is considered to have screened positive if the sum of these items is 4 or greater. The abbreviated PCL-C is a subset of the PCL-C, which is available through the National Center for PTSD at: http://www.ncptsd.va.gov/ncmain/ncdocs/assmnts/ptsd_checklist_pcl.html

From “An Abbreviated PTSD Checklist for Use as a Screening Instrument in Primary Care,” A. J. Lang, M. B. Stein, 2005, *Behaviour Research and Therapy*, 43, p. 585-594. Copyright 2005 by Elsevier. Adapted with permission of the author.



THE SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

FEB 5 2004

MEMORANDUM FOR THE UNDER SECRETARY OF DEFENSE
(PERSONNEL AND READINESS)

SUBJECT: Department of Defense Care for Victims of Sexual Assaults

I am concerned about recent reports regarding allegations of sexual assaults on service members deployed to Iraq and Kuwait. Sexual assault will not be tolerated in the Department of Defense. Commanders at every level have a duty to take appropriate steps to prevent sexual assaults, protect victims, and hold those who commit offenses accountable. I am directing that you review how the Department handles treatment of and care for victims of sexual assault, with particular attention to any special issues that may arise from the circumstances of a combat theater. We are responsible for ensuring that the victims of sexual assault are properly treated, their medical and psychological needs are properly met, our policies and programs are effective, and we are prompt in dealing with all issues involved.

Your review should address the reporting of sexual assaults, including the availability of private channels for reporting such issues within combat theaters. During the course of your review, you should also consider what briefings may need to be given to deploying and redeploying service members.

Please report your findings and recommendations 90 days from the date of this memorandum.



OSD 01728-04

Figure 5. Memorandum from the secretary of defense requesting evaluation of sexual assault allegations amongst the military branches. From “*Task force report on care for victims of sexual assault*,” by the Department of Defense Task Force, 2004. This is a government document in the public domain.

Abstract

Objective. For the first time, thousands of women who have fulfilled their military obligations will be returning to civilian society without comprehensive evaluations of the effects of war on them, especially those who endured military sexual assault. The importance of this literature review is to educate health-care professionals on the issues female soldiers from combat zones face while on duty and upon returning to society. **Methods.** This literature review will focus on female sexual assault literature from peer-reviewed articles, government websites (NCPTSD, DoD, etc.), newspaper publishings, databases (Medline, Pubmed, etc.), and articles comparing the current wars on Iraq and Afghanistan to prior wars, searched within the dates of 1965 to present. **Conclusion.** If healthcare professionals can prevent further deterioration from military sexual assault, it will aid female soldiers in post-combat life and possibly decrease suicide/femicide, substance abuse, gynecological issues, intimate partner violence, and PTSD rates in sexually assaulted female veterans.